ORANGE COUNTY IN-HOME SUPPORTIVE SERVICES
PUBLIC AUTHORITY
PROVIDER APPLICATION

NAME:_____ **M____ F____**
Last First M.I.

Mailing Address:_____
Street City Zip

Phone:_____ **Soc. Sec. #** _____ **Driver License #** _____

Message Phone:_____

Days and Hours Desired:

Mon ☐ **Tue** ☐ **Wed** ☐ **Thu** ☐ **Fri** ☐ **Sat** ☐ **Sun** ☐

Mornings ☐ **Afternoons** ☐ **Evenings** ☐ **Overnight** ☐

Hours per week Desired?_____ Live-in?_____ Holidays?_____

Please check the areas where you would be willing to work.

North County		**Central County**		**South County**	
Anaheim	☐	**Garden Grove**	☐	**Aliso Viejo**	☐
Brea	☐	**Santa Ana**	☐	**Laguna Beach**	☐
Buena Park	☐	**Stanton**	☐	**Laguna Hills**	☐
Fullerton	☐	**Seal Beach**	☐	**Laguna Woods**	☐
La Habra	☐	**Westminster**	☐	**Laguna Niguel**	☐
La Palma	☐	**Los Alamitos**	☐	**Lake Forest**	☐
Placentia	☐	**Fountain Valley**	☐	**San Clemente**	☐
Yorba Linda	☐	**Orange**	☐	**San Juan Capistrano**	☐
Other:_____				**Mission Viejo**	☐

Do you smoke?____ Would you work for a smoker?____ Do you speak/read English?___

Form of transportation?_____ Client preference? M___F___ Will you use your car?___

Drive clients car?___ Do you have car insurance?___ Will you work with pets ?___

Are you married?___ Do you have children?___ Educational background_____

Which of the following would you be willing to work with:

☐ **Adults**
☐ **Children**
☐ **Elderly**
☐ **Developmental Disabilities**
☐ **Physical Disabilities**
☐ **Memory Problems**
☐ **Aids**
☐ **Terminal Illnesses**

LIST WORK EXPERIENCE AND/OR TASKS YOU ARE WILLING TO PERFORM.

- ☐ **Accompaniment to Alternative Resources**
- ☐ **Accompaniment to Medical Resources**
- ☐ **Ambulation**
- ☐ **Bathing – Oral Hygiene – Grooming**
- ☐ **Bowel and Bladder Care**
- ☐ **Care and Assistance with Prosthesis**
- ☐ **Clerical Skills such as Filing or Writing**
- ☐ **Domestic Services**
- ☐ **Dressing**
- ☐ **Feeding**
- ☐ **Heavy Lifting**
- ☐ **Meal Clean up**
- ☐ **Menstrual Care**
- ☐ **Moving in and out of bed**
- ☐ **Other shopping errands**
- ☐ **Paramedical Services**
- ☐ **Preparation of Meals**
- ☐ **Protective Supervision**
- ☐ **Reading for Consumers**
- ☐ **Respiration**
- ☐ **Routine Bed Baths**
- ☐ **Routine Laundry**
- ☐ **Rubbing Skin – Repositioning**
- ☐ **Shopping for Food**
- ☐ **Teaching and Demonstrating**

Do you have any health problems that would limit your ability to complete any of these tasks?
If so explain:_____

Allergies:_____

Other Languages Spoken:_____

Do you give the Registry permission to conduct a criminal background check?_____

Have you ever been convicted of a felony? Yes ☐ No ☐

If yes, please explain:_____

List any training you have had related to In-Home Care:_____

List any certificates or licenses you possess:

___First aid Expires_____ ___CNA Expires_____

___CPR Expires_____ ___CNHA Expires_____

How many years experience providing in-home care do you have?_____

How did you hear about us?_____

References:

On the following page please list your work experience, beginning with your most recent employment. If you do not have work references we can contact, please list other references such as volunteer experience, baby sitting, house cleaning, etc.

Employment

1. **Employer Name:_____ Related Duties:_____**
   Address:_____ Reason for leaving:_____
   City. State, Zip:_____ Employment dates:_____ to _____
   Supervisor Name/Phone:_____

2. **Employer Name:_____ Related Duties:_____**
   Address:_____ Reason for leaving:_____
   City, State, Zip:_____ Employment Dates:_____ to_____
   Supervisor Name/Phone:_____

3. **Employer Name:_____ Related Duties:_____**
   Address:_____ Reason for leaving:_____
   City, State, Zip:_____ Employment Dates_____ to _____
   Supervisor Name/Phone:_____

Personal

List three people you know personally whom we can contact as a reference only one can be a relative.

1. **Name:_____ Home Phone:_____**
   How do you know:_____Work Phone;_____
   How long known:_____

2. **Name:_____ Home Phone:_____**
   How do you know:_____ Work Phone: _____
   How long known:_____

3. **Name:_____ Home Phone:_____**
   How do you know:_____ Work Phone:_____
   How long known:_____

I certify that the above is true. I understand that any false information may eliminate me from enrollment. I understand that my name may be placed on a list to be given to persons who are seeking assistance in their homes.

I understand that the information on this application may also be shared with prospective employers. I also understand that my employer is not Orange County In-Home Supportive Services Public Authority. The IHSS client is my employer.

_____ _____

Signature Date